MedMal DIRECT
Insuring a Healthy Practice

CHECKLIST

Documentation Policy

Documentation of medical records is a vital component of patient care and it fulfills many purposes. It serves as a recorded chronology of the patient's medical history and tells the story of the care and treatment provided to the patient. It also facilitates communication among caregivers, is the foundation of proper coding and billing, and could provide evidence that is crucial to the defense of a legal action.

Proper documentation should be implemented within all healthcare organization through written policies and procedures. The policies should encourage providers and staff to be detailed and consistent in their documentation of patient care. The checklist below was designed to assist healthcare administrators, providers and staff evaluate their current documentation policies and practices and to identify potential areas for improvement.

	Yes	No
DOCUMENTATION POLICIES		
Does your Medical Practice currently have a written documentation policy?	☐	☐
Your current documentation policy:		
• Provides specific requirements regarding format of documentation, content, review of records, and signoff	☐	☐
• Provides information about accountability and responsibility for various types of documentation	☐	☐
• Contains detailed guidance about alteration of patient records, including how to appropriately amend a record, and guidance for when alteration is prohibited	☐	☐
• Strictly prohibits negative, judgmental, or subjective comments about patients and their families in health records and other forms of documentation	☐	☐
• Establishes proper notation methods to prevent misunderstandings about the level of care or the timing of care	☐	☐
• Stipulates that dictated and transcribed documentation must be reviewed and approved by appropriate and qualified healthcare personnel	☐	☐
• Encourages appropriate use of checklists and forms	☐	☐
• Establishes appropriate terminology and medical abbreviations to avoid confusion and medical errors	☐	☐
• Establishes appropriate timeframes for completion of documentation-related tasks, such as medical record entries, review of transcribed information, and signoff of consultative reports	☐	☐
• Accounts for unique risks related to electronic documentation	☐	☐

	Yes	No
CLINICAL ENCOUTER		
Thorough information is documented for patients during initial clinical encounters and at each follow-up visit, including:		
• Medical and family history	☐	☐
• Medications, including prescription and over-the-counter medications, vitamins, supplements, and herbal remedies	☐	☐
• Drug, material, and food allergies (including the name of the allergen, the date the allergy was identified, and the patient's reaction)	☐	☐
• Physical exam findings	☐	☐
• Differential diagnosis and final diagnosis	☐	☐
• Recommended screening and tests, as well as results	☐	☐
• Treatment plans and the provision of care, including clinical rationale	☐	☐
• Administration of medications or vaccines during the clinical encounter	☐	☐
• Patient education, including techniques used to improve comprehension or address health literacy barriers (e.g., the teach-back technique)	☐	☐
• Referrals and consultations	☐	☐
• Follow-up for persistent problems	☐	☐
Informed consent discussions are documented, including risks and benefits, treatment alternatives, self-care regimens, and patient education	☐	☐
Issues related to patient nonadherence are documented, including methods used to address compliance issues (e.g., additional education, behavior contracts, etc.)	☐	☐
When documenting patient encounters, healthcare providers use language that is specific and objective. They use direct patient quotes to clarify context	☐	☐

	Yes	No
ADMINISTRATIVE/ SYSTEMS		
The Practice has a system in place to document:		
• All tests and consultations ordered	☐	☐
• All test results and consultative reports received	☐	☐
• Test results and consultative reports reviewed by an appropriate and qualified healthcare provider	☐	☐
• Any clinical decisions based on test results or consultations, including rationale	☐	☐
• Patient notification of test results and consultative reports	☐	☐
The Practice has policies and processes in place to ensure hospital records and information from other healthcare providers are incorporated into patient records.	☐	☐
Telephone calls to pharmacies are documented, including the name of the pharmacy, phone number, medication prescribed, dose, schedule, volume dispensed, and number of refills authorized.	☐	☐
If the patient or pharmacist is notified that the patient must be seen prior to the next refill, this information is also documented in the patient's health record.	☐	☐
AUDITING		
The Practice's documentation policies are periodically audited to identify gaps and information that requires updating.	☐	☐
Hardcopy records are periodically reviewed to ensure they are legible and chronological, and that all entries are dated and signed.	☐	☐
The tracking process for test results and consultative reports is periodically reviewed to ensure entries have appropriate dates, times, and reviewer signatures.	☐	☐
Disclosure of patient health records and protected health information is periodically reviewed for compliance with organizational policies on release of patient records.	☐	☐

	Yes	No
STAFF EDUCATION		
Healthcare providers and staff members receive education about the organization's documentation policies during orientation and as part of in-service training.	☐	☐
Staff is educated about the risks associated with:		
• Inclusion of incident reports or lawsuit-related correspondence in medical records	☐	☐
• Using legal terms such as "negligence," "duty," or "liability" in the medical record	☐	☐
• Speculation about, or criticism of, the actions of other healthcare professionals within the medical record	☐	☐
Staff is aware of the Practice's policy regarding the release of a patient's medical record and/ or protected health information.	☐	☐